



Hansa Medical Group
Patient Medical History

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Main Medical Issue(s) \_\_\_\_\_

Medication & Food Allergies \_\_\_\_\_

Past Hospitalizations & Surgeries \_\_\_\_\_

Current Medications & Doses \_\_\_\_\_

Social History

Occupation \_\_\_\_\_

Marital Status \_\_single \_\_married \_\_Widowed \_\_divorced

Any Children? Y or N If yes, how many \_\_\_\_\_

Current Smoking? Y or N packs per day? \_\_\_\_\_

Past smoking History? Y or N quit date? \_\_\_\_\_

Illicit drug use? Y or N What kind? \_\_\_\_\_

Family History.

Please name any and all diseases that run in your family.

- Allergies/Hayfever Y or N
Alzheimer's Disease Y or N
Arthritis Y or N
Cancer Y or N
Type I or II Diabetes Y or N
High Cholesterol Y or N
High Triglycerides Y or N
Heart Arrhythmia Y or N
High Blood Pressure Y or N
Kidney Disease Y or N
Liver Disease Y or N
Lung Disease Y or N
Multiple Sclerosis Y or N
Osteoarthritis Y or N
Osteoporosis Y or N
Parkinson's Disease Y or N
Seizures/Epilepsy Y or N
Sinus Disease Y or N
Stroke Y or N
Thyroid Imbalance Y or N
Tuberculosis Y or N
Heartburn or GERD Y or N